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Final Enrollment Rates Show Federally run Marketplaces Make up Lost Ground at end of Enrollment

Abstract

This new data brief updates our interim March 2014 findings with enrollment rates at the close of the Affordable Care Act's first open enrollment period. It focuses on enrollment rates by state and type of marketplace, and assesses changes in enrollment rates in the final six weeks. The final enrollment figures reveal that the federally facilitated marketplaces and some of the troubled state-based ones made up some ground in the last four to six weeks of the open enrollment period.

Keywords

health insurance, private insurance/exchanges

Disciplines

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Deciphering the Data: Final Enrollment Rates Show Federally Run Marketplaces Make Up Lost Ground at End of Open Enrollment

In-Brief

The ACA gave states a number of choices in how to implement the broad coverage changes it required. As such, health reform looks different from state to state, and the impact of the ACA may differ because of these state decisions. This Data Brief examines a number of choices related to the establishment and running of the new health insurance marketplaces, and their impact on enrollment rates to date. Here we update our interim [March 14](#) findings with enrollment rates at the close of open enrollment. We look at enrollment rates by state and type of marketplace, and assess changes in enrollment rates in the final six weeks. The final enrollment figures reveal that the federally facilitated marketplaces and some of the troubled state-based ones made up some ground in the last four to six weeks of the open enrollment period.

One of the linchpins of the Affordable Care Act (ACA) is the establishment of “Health Insurance Exchanges” [now called “Marketplaces”] where consumers can select health plans they prefer among various combinations of coverage and premiums. As originally intended, these marketplaces would be state-based, with a default federally facilitated marketplace in states that were unable or unwilling to establish their own. The state could run its marketplace through an existing or new state agency, a quasi-governmental organization, or a non-profit entity.

The law specified [five core functions](#) for the exchanges: determining eligibility; enrolling individuals; conducting plan management activities (e.g., certifying health plans as “qualified” to be sold, rate review, regulating marketing); assisting consumers (e.g., in-person help, “Navigators,” websites, and call centers); and providing financial management services (e.g., accounting, auditing, and reporting).

As it turned out, just 16 States (and DC) established their own marketplaces; 27 states chose, or defaulted to, a federally run marketplace. Because of time constraints, two of the state-based marketplaces (New Mexico and Idaho) are using the federal IT platform while they develop their own. In 2011 regulations, states were offered the option of a federal state partnership, in which states could retain consumer assistance and plan management functions, and seven states chose that option. In early 2013, states choosing the federally run

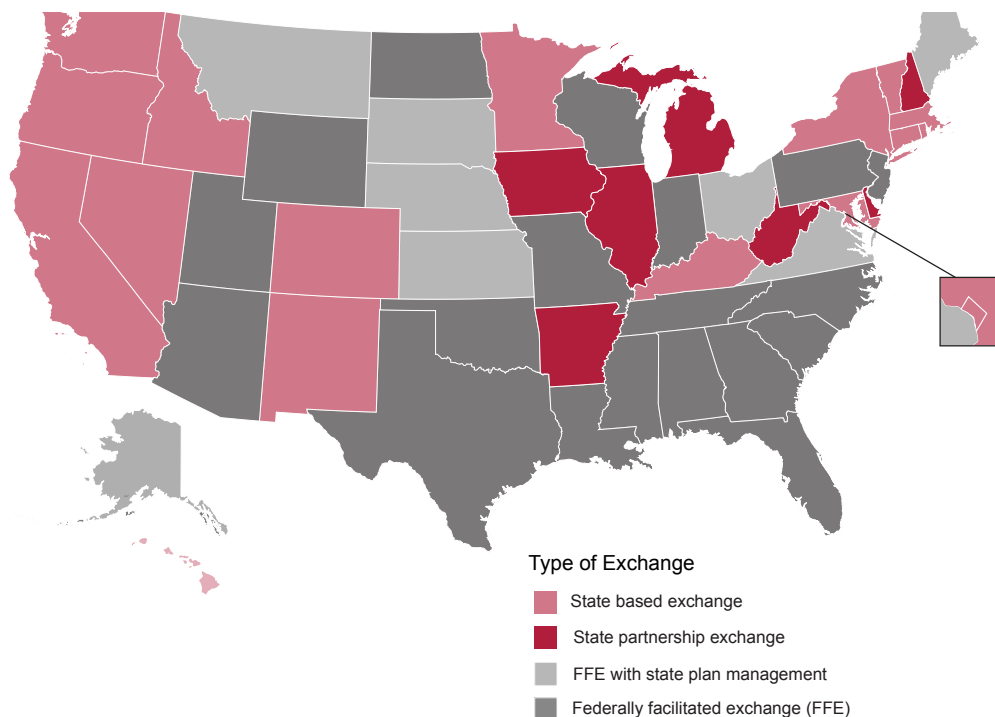
marketplace were given the option of taking on only plan management functions, and seven states chose that option.

DID MARKETPLACE TYPE CORRELATE WITH ENROLLMENT RATES?

Given the variability in how states have implemented this aspect of the ACA, it is reasonable to ask how these decisions have affected each state’s ability to enroll its target population into plans on the marketplace. Have states of one type or another had higher enrollment rates? The Data Brief looks at the individuals who selected a marketplace plan for the initial open enrollment period. This covers October 1, 2013 through March 31, 2014. It also includes the additional Special Enrollment Period (SEP) activity reported through April 19, 2014, which includes information for people “in line” on March 31 (as well as those enrolling for other reasons such as a qualifying life event). These data are provided by the Assistant Secretary for Planning and Evaluation (ASPE), Department of Health and Human Services (HHS). In this brief we refer to the count of individuals who have selected a marketplace plan as “enrollment,” but technically this is “pre-effectuated enrollment” because it includes those who have selected a plan with or without the first premium payment having been received directly by the marketplace or the issuer.

Health insurance marketplaces were created by the ACA as a way to make health insurance more affordable and easier to purchase for individuals. (The ACA also created marketplaces for small businesses, which is beyond the scope of this brief.) The purpose was to extend affordable coverage to the uninsured who do not qualify for Medicaid, as well as to make coverage more secure for those who purchase insurance on the individual market. Thus, capturing enrollment success would ideally entail capturing the degree to which the marketplaces are meeting intended enrollment goals. An overall basic enrollment objective is for the marketplaces to enroll as many of the potentially eligible enrollees as possible. But given the goals of the ACA, covering as many eligible uninsured would be a more specific way to capture marketplace success. However, the enrollment numbers available do not provide sufficient detail to provide a direct link to this measure of success. While no measure is perfect, given the data available at this point, we measure total enrollment as a fraction of the potential population for the marketplace in each state, including the uninsured not eligible for Medicaid and people with plans on the individual market. Here we use the percentage of eligible people as calculated by the [Kaiser Family Foundation](#). They include legal residents who are uninsured or purchase non-group coverage, have incomes above Medicaid/CHIP eligibility levels, and who do not have access to employer-sponsored coverage. The estimate

Type of Health Insurance Marketplace Exchange



excludes uninsured individuals with incomes below the poverty level who live in states that did not elect to expand the Medicaid program. We call this measure the enrollment rate.

WHAT WE FOUND

Overall, more than 8.0 million people have enrolled and picked a plan through the exchanges, about 28% of all potential eligibles. We found that, on average, state-based marketplaces have had higher enrollment rates (32.5% of eligibles) than the federally facilitated ones (26.3%) or the partnership states (26.0%). The states retaining plan management functions within a federally facilitated marketplace have slightly lower rates than the other federally run ones (22.0% vs. 27.0%).

These averages, however, hide significant differences among the states and within the types of marketplaces, especially the state-based marketplaces. Within the federally run marketplaces, enrollment rates vary from 11% in South Dakota to 39% in Florida. Enrollment rates in the state-based marketplaces vary from 12% in Massachusetts to 85% in Vermont. We should note that these two extremes are likely outliers. Vermont's rate might reflect the mandatory nature of its exchange (no individual policies are sold outside of the exchange). And in Massachusetts, many of the eligibles not enrolled in the marketplace have insurance, but have not been counted due to systems and processing problems in transitioning people from existing state programs and platforms.

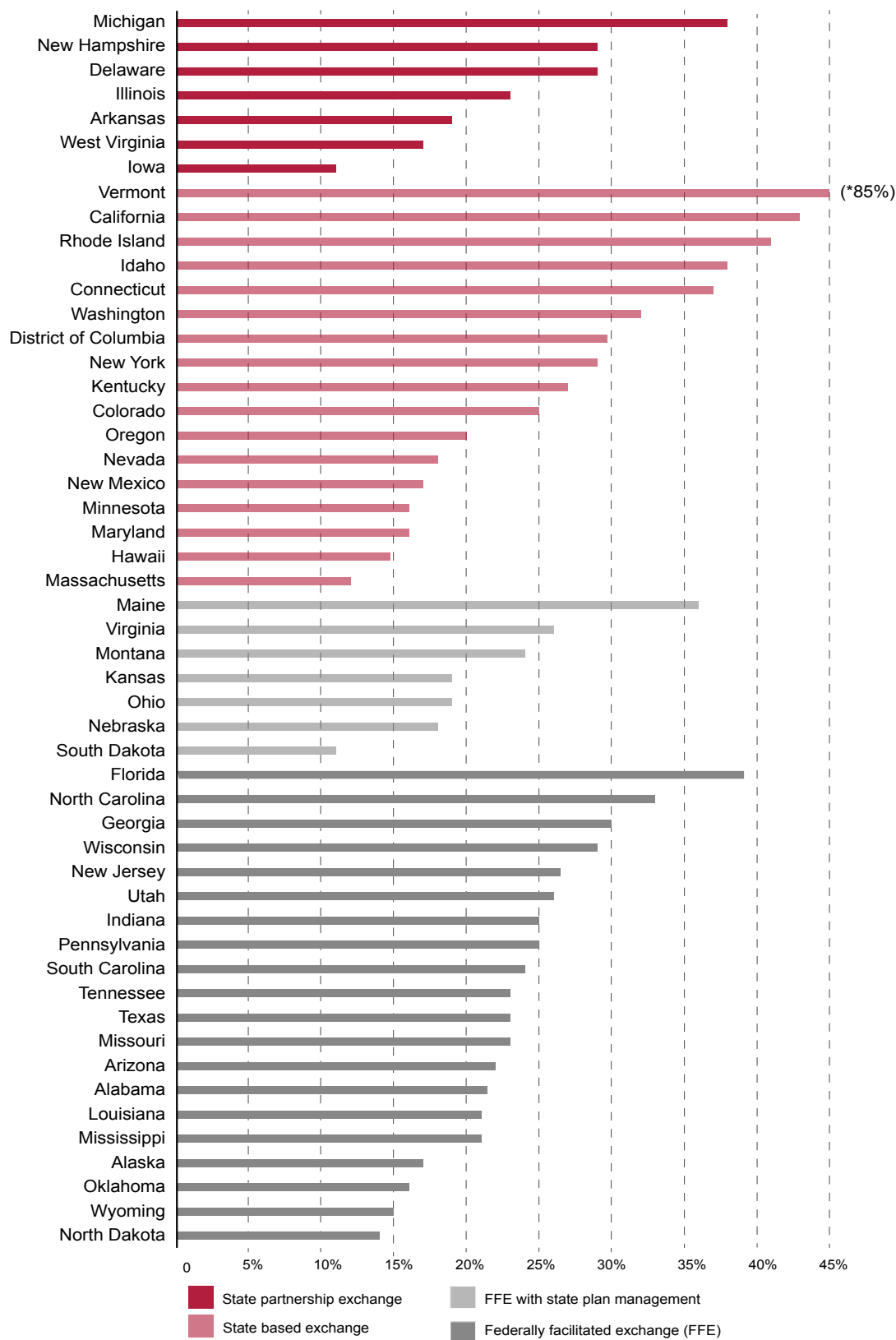
In our original interim brief, we found that the "average" state-based marketplace was doing as well in its enrollment as the best federally run exchange. We noted that all of the federally

facilitated marketplaces were likely affected by the extremely difficult rollout of the HealthCare.gov site when it launched on Oct. 1, 2013, as were the two state-based marketplaces relying on the federal site (New Mexico and Idaho). Many of the less-successful state-based marketplaces, particularly Massachusetts, Minnesota, Oregon, Maryland, and Hawaii, also had [documented problems](#) with the rollout of their sites, which was likely reflected in their enrollment rates.

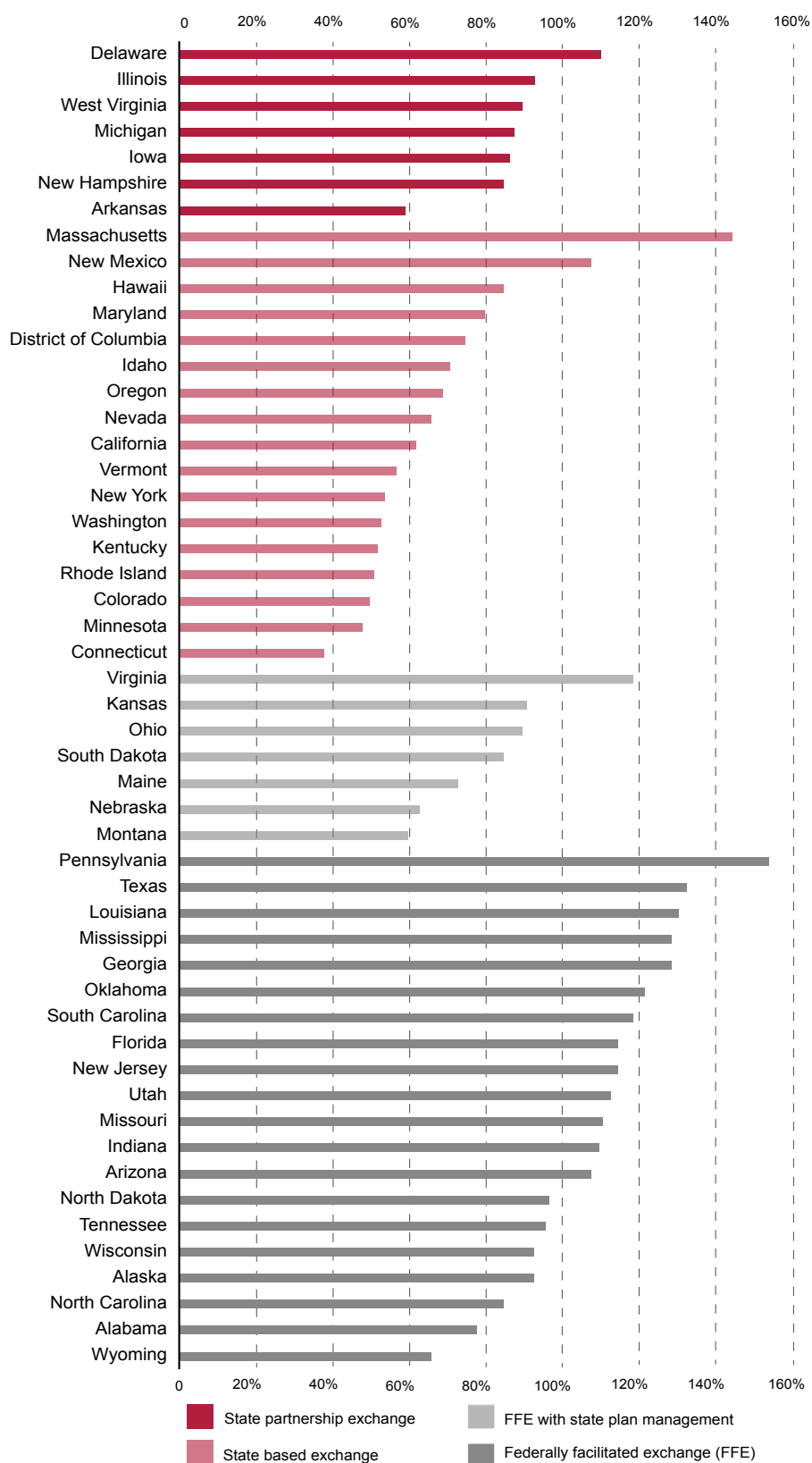
The final enrollment figures reveal that the federally facilitated marketplaces and some of the troubled state-based ones made up some ground in the last four to six weeks of the open enrollment period. Enrollments in the federally run marketplaces rose 111%, compared to an 89% increase in the partnership states and a 60% increase in the state-based marketplaces. Federally run marketplaces in Florida (39%) and North Carolina (33%) outperformed the state-based marketplace average.

Each state choosing to run its own marketplaces decided on a formal governance structure, and that decision seems to have made a difference in initial enrollment rates. Each option had its [potential advantages and disadvantages](#). Housing a marketplace in a state agency might allow the state to use its existing infrastructure and resources most efficiently; it might also overwhelm an existing agency and subject the new marketplace to cumbersome state rules and regulations. States choosing to create a quasi-governmental organization, on the other hand, would have government oversight but more flexibility in its processes, such as hiring and procurement. But this option also involves investing in new infrastructure, and managing new relationships with state agencies. Creating a non-profit entity might give a state the most flexibility, and perhaps increase its

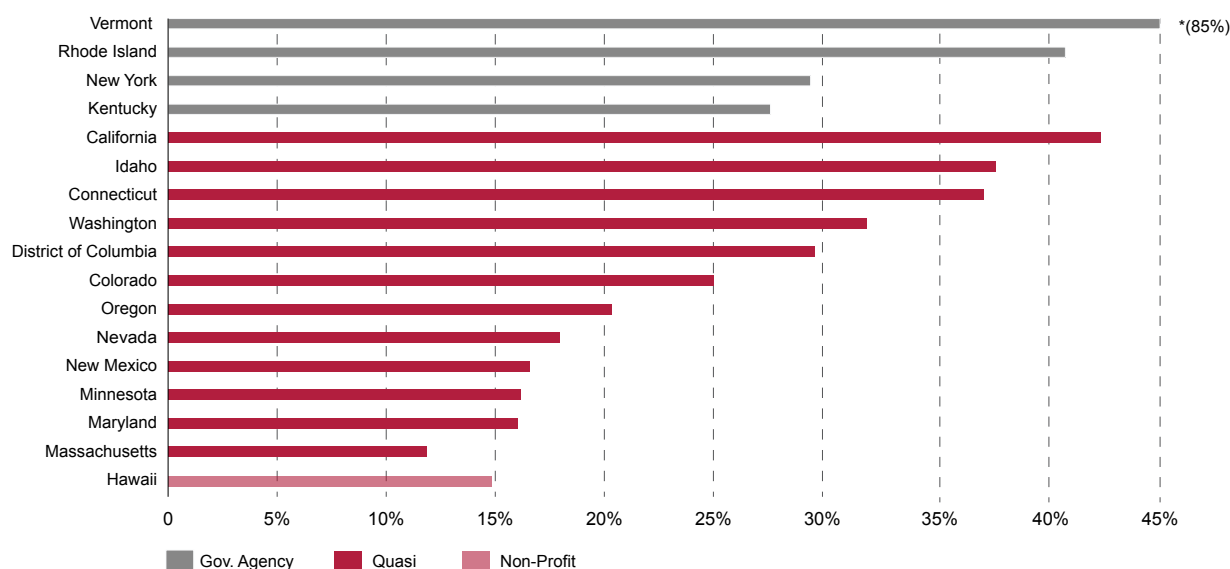
Federally Facilitated, State-Based and Partnership Health Insurance Marketplace Enrollment as a Percent of Potential Enrollees



Enrollment Surge in Final Month of Open Enrollment % Change by State Categorized by Marketplace Type



State-Based Health Insurance Marketplace Enrollment as a Percent of Potential Enrollees by Governance Structure for Exchange



consumer-friendliness; however, this non-governmental entity might also have the most difficulty interacting with the state's agencies and databases.

Twelve states chose a quasi-governmental organization to govern their exchange; four states chose an existing state agency, and only one, Hawaii, chose to create a non-profit entity (although Arkansas will transition from a partnership to state-based marketplace in July 2015 and has decided on non-profit governance). The four states that chose an existing state agency had higher enrollment rates in the first five months of enrollment; however, by the end of open enrollment, the difference between state agencies and quasi-governmental organizations had disappeared. In the final six weeks, marketplaces based in quasi-governmental organizations had an 87% increase in enrollment, compared to a 52% increase in state agency-based marketplaces.

WHAT DOES IT MEAN?

Traditionally, states have regulated their own insurance markets. The ACA introduced what has been called a “[hybrid federalism](#)” into the process. In effect, the ACA became a case study in the political and organizational factors affecting [state-level implementation of a federal mandate](#). Because of [partisan divides](#), legal delays, and technological glitches, the implementation of the ACA differed from state to state. It is likely that all these factors contributed to the wide variation across states in enrollment success in the first five months of open enrollment. Given their traditional role in regulating insurance, it is not surprising that state-based marketplaces had the greatest initial success, and that state-based marketplaces governed by existing state agencies had the fastest start. Perhaps the biggest surprise was the extent of the increase in enrollments in many federally facilitated marketplaces at the end of open

enrollment. This suggests that these structural decisions may ultimately not be as important in enrollment success as more process-oriented ones, such as marketing and outreach to eligible populations, and consumer assistance in navigating the new marketplaces.

There are many aspects of success our measure does not capture. First, as mentioned above, we do not separate enrollees who were uninsured from those who had individual insurance. Second, we do not address the degree to which enrollees have high health care needs, which could affect pricing in future years. Third, our measure does not account for the variation in the number of people still purchasing individual insurance outside the exchanges. It is possible that our measure may artificially understate coverage success in those states with relatively robust individual markets, because potential enrollees may be more likely to continue to purchase individual insurance outside the exchange. Fourth, while the number is likely to be small, some exchange participants were previously insured in the employer-sponsored market and thus not reflected among “potential enrollees.” Fifth, some of those enrolled may fail to pay their premiums and therefore quickly lose their enrollment status.

With 8 million people enrolled in private plans through the exchanges, the ACA has reached initial enrollment targets. But by our measure, more than 70% of the potential eligible population has not enrolled through the new exchanges. When the data are available, it will be important to understand who has enrolled through the exchanges, who has maintained or purchased insurance off the exchanges, and who remains uninsured. Targeting the remaining uninsured will be critical to the success of the next open enrollment period, which runs from Nov. 15, 2014 to Feb. 15, 2015.

About the Authors

This Data Brief was written by Daniel E. Polsky, PhD, MPP, Janet Weiner, MPH, Christopher Colameco, and Nora Becker.

About The Leonard Davis Institute of Health Economics

The [Leonard Davis Institute of Health Economics](#) (LDI) is the University of Pennsylvania's center for research, policy analysis, and education on the medical, economic, and social issues that influence how health care is organized, financed, managed, and delivered. LDI, founded in 1967, is one of the first university programs to successfully cultivate collaborative multidisciplinary scholarship. It is a cooperative venture among Penn's health professions, business, and communications schools (Medicine, Wharton, Nursing, Dental Medicine, Law School, and Annenberg School for Communication) and the Children's Hospital of Philadelphia, with linkages to other Penn schools, including Arts & Sciences, Education, Social Policy and Practice, and Veterinary Medicine.

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